are so broad that concerns about self referral conflicts are greatly minimized. But that is not the case for specialty hospitals.

Most specialty hospitals are jointly owned by the hospitals and groups of physicians who are referring patients to that hospital. Typically, these joint ventures are marketed only to physicians in a position to refer patients to the facility. In these situations, there is great potential for conflicts-of-interest for physicians who refer patients to facilities in which they have an ownership interest. These joint ventures may induce investor physicians to base their treatment decisions on profits generated by the facility rather than on the clinical needs of their patients. This is exactly the type of behavior the Stark laws were written to prevent.

The development of specialty hospitals is of great concern to our health care system and to communities across our nation because they deprive full-scale hospitals of their most profitable business, leaving those existing hospitals much worse off financially. The investors in these joint ventures and specialty hospitals skim the profits off full-scale hospitals, leaving them to struggle financially. Then the hospitals must look to Medicare and to their local communities to help them financially.

One of the biggest chains of heart hospitals in this country is a company called the MedCath Corporation. One needs only look at their financial statement to see that they recognize the level of concern felt around the nation about their line of business. Their 2002 10–K report highlights nervousness that regulators and legislators are catching onto their scheme. As the report states:

''Many states in which we operate also have adopted, or are considering adopting physician self-referral laws which may prohibit certain physician referrals or require certain disclosures.'' They also highlight specific concerns about our bill from the last Congress and go on to say that, ''Possible amendments to the Stark law could require us to change the manner in which we establish relationships with physicians to develop a heart hospital.''

MedCath is right to be nervous. Their business model not only harms hospitals and communities, it violates the spirit of Medicare self referral laws intended to prohibit such conflicted behavior that drives up costs and may produce unnecessary care. Lawyers for MedCath and many others have found a loophole in the self-referral laws, and physicians are taking advantage of it.

The bill we are introducing today would close that loophole. Our bill would continue to permit physician ownership in these joint ventures and specialty hospitals. But, that allowance is contingent on a new requirement that the ownership or investment interest is purchased on terms that are generally available to the public at the time. This change would not prohibit physicians from purchasing shares of stock. However, it would make sure that such stock purchases are not the result of a sweetheart deal available only to physicians and set up in a way to skirt the law.

If this bill is enacted, it will make it harder for specialty hospitals and physicians to skim profits from full-scale hospitals leaving it up to Medicare and local communities to foot the bill to assure that access to needed patient care isn't jeopardized.

Mr. Speaker, it is time to close this loophole in the Medicare physician self-referral laws, and I urge my colleagues to support it.

PERSONAL EXPLANATION

HON. XAVIER BECERRA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, April 1, 2003

Mr. BECERRA. Mr. Speaker, on Thursday, March 27, 2003, 1 was unable to cast my floor vote on rollcall numbers 90 and 91. The votes I missed include rollcall vote 90 on Suspending the Rules and Agreeing to H. Res. 153, Recognizing the public need for fasting and prayer; and rollcall vote 91 on Suspending the Rules and Agreeing to H. Con. Res. 118, Concerning the treatment of members of the Armed Forces held as prisoner of war.

Had I been present for the votes, I would have voted ''present'' on rollcall vote 90 and ''aye'' on rollcall vote 91.

RECOGNIZING ROBERT PETCOFF FOR ACHIEVING THE RANK OF EAGLE SCOUT

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, April 1, 2003

Mr. GRAVES. Mr. Speaker, I proudly pause to recognize Matthew Robert Petcoff, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 261, and in earning the most prestigious award of Eagle Scout.

Matthew has been very active with his troop, participating in such scout activities as the H. Roe Bartle Summer Camp for six years, the Philmont High Adventure and Troop Camping. Over the 12 years he has been involved in scouting, Matthew has earned 36 merit badges. Additionally, he has held numerous leadership positions, serving as troop scribe, chaplain's aide, assistant patrol leader, troop guide, and troop trainer. Matthew also has been honored for his numerous scouting achievements with such awards as the Parvuli Dei Catholic Religious Award, the Ad Altare Dei Catholic Religious Medal, and the Warrior in the tribe of Mic-O-Say Award.

For his eagle scout project, Matthew created a landscaped flagpole area with a cement walkway for the Hills of Walden Neighborhood Clubhouse in Kansas City, Missouri.

Mr. Speaker, I proudly ask you to join me in commending Matthew Robert Petcoff for his accomplishments with the Boy Scouts of America and for his efforts put forth in achieving the highest distinction of Eagle Scout.

CLOSE THE LOOPHOLE IN MEDICARE PHYSICIAN SELF-REFERRAL LAWS

HON. GERALD D. KLECZKA

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, April 1, 2003

Mr. KLECZKA. Mr. Speaker, today Congressman STARK and I are reintroducing legislation, the Hospital Investment Act, sponsored initially in the 107th Congress, to address serious concerns about conflicts-of-interest raised by specialty or so-called ''boutique'' hospitals with physician-investor ownership arrangements.

Across the nation, there is a tremendous growth of boutique hospital construction. In the Milwaukee-area alone, there are three boutique heart hospitals under development. These facilities are not typical, general hospitals, which are prepared to meet the wide variety of health needs within a community. Instead, these entities specialize in one area of procedures, such as cardiac care or orthopedic surgery, that is high-volume and high-profit to these investor-owned facilities.

One major consideration with the proliferation of these boutique hospitals is the issue of self-referral, in which doctors send their patients to facilities where they have a preferential financial ownership stake. Current federal law forbids a physician from referring patients to health facilities—such as clinical laboratories, physical therapy groups, and radiology centers—in which he or she stands to financially benefit.

These Stark I and Stark II laws did provide one exception that allows physicians to self-refer patients to hospitals, as long as it is a ''whole hospital'' and not just a particular department or clinic within the facility. Since whole hospitals provide such a wide array of health services, there was minimal risk of conflict-of-interest. Unfortunately, this exception has become a loophole by which physicians can legally refer patients to freestanding boutique hospitals where they have a direct personal financial interest.

Typically, stakes in these boutique hospital ventures are marketed exclusively to doctors in a position to refer patients to the facility. This preferential interest creates an inducement for investor-physicians to overutilize services and base treatment decisions on profits rather than the medical needs of the patient. As we have seen in the past, these arrangements invariably lead to increased health care spending without necessarily increased quality of patient care. This is exactly the scenario that the Stark laws were designed to prevent.

Boutique hospitals also rob full-service community hospitals of their most profitable lines of business, leaving them to struggle to stay afloat financially. Without the high-profit surgical units to cross-subsidize the other less-profitable—but equally important—services like emergency and burn care, these hospitals will have to turn increasingly to the federal government as well as their local communities for financial assistance. Medicare, Medicaid, and other important programs, which are already stretched thin, should not be forced to take on this additional burden because these joint ventures are skimming off large profits for their investors.

The Hospital Investment Act of 2003 would close this loophole by prohibiting preferential hospital ownership terms for physicians. Under this legislation, physicians could continue to refer patients to joint ventures and specialty hospitals, but only if their ownership or investment interest is purchased on terms also available to the general public at the time. This would ensure that stock purchases are not a result of a special deal available only to physicians that gives them a preferential share of the profits.

Physicians and facilities found in violation of this act would be subject to a civil monetary